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	17E181	A. BUILDING _____ B. WING _____	06/25/2014

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CITIZENS MEDICAL CENTER LTCU	1625 S FRANKLIN AVE COLBY, KS 67701

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F 000	INITIAL COMMENTS The following citations represent the findings of a Health Resurvey.	F 000		
F 241 SS=D	483.15(a) DIGNITY AND RESPECT OF INDIVIDUALITY The facility must promote care for residents in a manner and in an environment that maintains or enhances each resident's dignity and respect in full recognition of his or her individuality. This Requirement is not met as evidenced by: The facility had a census of 51 residents. The sample included 13 residents. Based on observation and interview the facility failed to maintain an environment that promotes the dignity of all resident by posting a sign visible to other residents and/or visitors with confidential information for 1 of 13 sampled residents. (#53) Findings included: - On 6/17/14 at 8:42 AM, observation revealed a Family and Visitor Education sign, stating your loved one is in contact precautions. These precautions prevent spread of infection. This type of infection is spread by directly touching the resident or something they have touched, outside the resident's door on the wall below his/her room number visible to residents and visitors. On 6/17/14 at 8:43 AM, Administrative Nurse F verified the staff posted the sign on the wall in the hall by the resident's door. Administrative Nurse F stated the staff should not post the sign outside a resident's door who is on contact isolation. The facility's undated Resident Rights policy indicated the resident had the right to a dignified	F 241		

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE | TITLE | (X6) DATE

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F 241	Continued From page 1 existence and access to services inside and outside the facility. The facility failed to promote care in a manner to maintain and enhance dignity and respect for Resident #53.	F 241		
F 280 SS=D	483.20(d)(3), 483.10(k)(2) RIGHT TO PARTICIPATE PLANNING CARE-REVISE CP The resident has the right, unless adjudged incompetent or otherwise found to be incapacitated under the laws of the State, to participate in planning care and treatment or changes in care and treatment. A comprehensive care plan must be developed within 7 days after the completion of the comprehensive assessment; prepared by an interdisciplinary team, that includes the attending physician, a registered nurse with responsibility for the resident, and other appropriate staff in disciplines as determined by the resident's needs, and, to the extent practicable, the participation of the resident, the resident's family or the resident's legal representative; and periodically reviewed and revised by a team of qualified persons after each assessment. This Requirement is not met as evidenced by: The facility had a census of 51 residents. The sample included 13 residents. Based on observation, record review and interview the facility failed to follow the resident's care plan for 1 of 13 residents regarding denture wear. (# 6) Findings included:	F 280		

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F 280	Continued From page 2 - Residents #6's quarterly (MDS) Minimum Data Set 3.0 assessment, dated 3/30/2014, indicated the resident had intact cognition, required limited assistance with most (ADLs) Activities of Daily Living and was independent with eating. The MDS indicated the resident received a mechanically altered therapeutic diet. The 1/21/2014 (CAAs) Care Area assessment, for nutritional status, indicated the resident had upper dentures and wore them at meals, then removed the dentures after his/her meal. The CAAs indicated the resident received a regular diet with ground meat with a nutritional supplement, of Two Cal (high protein dense supplement), 4 ounces daily. The resident eats and drinks independently and received his/her meals in his/her room after readmission from the hospital on 1/08/2014. The resident was at risk for alteration in nutrition secondary to receiving a mechanically altered diet. The 4/08/2014 care plan instructed the staff to assist the resident to put his/her dentures in before eating, remove them after meals, and clean/soak the dentures. The care plan indicated the dentures needed to be soaked at night and directed the staff to provide set up help with oral cares for the resident with the morning and the evening cares. Further care plan review revealed the staff would cut up the food, except finger foods. The care plan indicated the resident preferred to stay in his/her room and received all meals in his/her room as a room tray. The 4/21/2014 dentist notes indicated the resident had an abscessed root tip with an extraction of another tooth, and the dentist	F 280		

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prescribed an antibiotic. The note indicated the resident was scheduled for an upcoming dentist appointment, on 7/08/2014 at 2:30 PM, for another tooth extraction.

On 6/17/2014 at 5:25 PM, observation revealed the resident seated in a recliner, in his/her room, dressed in street clothes and nicely groomed. Continued observation revealed the resident had missing lower front teeth and no upper teeth/dentures.

On 6/18/2014 at 8:045 AM, Nurse Aide I, verified the resident had missing bottom teeth and missing upper teeth with upper dentures. Nurse Aide I stated the resident does not wear the dentures in his/her room but would wear them when he/she left the building with this/her family.

On 6/18/2014 at 7:45 AM, Dietary manager J verified the resident had missing bottom teeth and the facility modified his/her regular diet with ground meats. Dietary manager J indicated the resident had requested to stay in his/her room and eat his/her meals due to back discomfort.

On 6/18/2014 at 4:23 PM, Administrative Nurse F, verified after he/she had visited with the resident he/she became aware the resident did not wear his/her upper dentures with meals as outlined in the care plan. Administrative Nurse F indicated the nurse aides are to inform him/her of the resident's refusal to wear his/her dentures and he/she would update the care plan accordingly.

The facility failed to provide review and revise Resident # 6's care plan during dental work to

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F 280	Continued From page 4 inform staff the resident no longer wore his/her dentures at meals.	F 280		
F 314 SS=G	483.25(c) TREATMENT/SVCS TO PREVENT/HEAL PRESSURE SORES Based on the comprehensive assessment of a resident, the facility must ensure that a resident who enters the facility without pressure sores does not develop pressure sores unless the individual's clinical condition demonstrates that they were unavoidable; and a resident having pressure sores receives necessary treatment and services to promote healing, prevent infection and prevent new sores from developing. This Requirement is not met as evidenced by: The facility had a census of 51 residents. The sample include 13 residents. Based on record review and interview, the facility failed to provide necessary treatment and services to prevent pressure sores from developing for 1 of 2 sampled residents who developed an avoidable unstageable pressure sore on his/her heel..(# 50) Findings included: - The facility admitted Resident #50, on 2/13/14, from the hospital after he/she had surgery for a hip fracture. Resident #50's physician's order, dated 2/19/14, indicated the resident had diagnoses of Dementia (an progressive mental disorder characterized by failing memory), confusion, gout(inflammation of the joints), neuropathy (diseases or malfunctions of the nerves), osteoarthritis, (degenerative changes to one or many joints characterized by swelling and pain and type II Diabetes Mellitus (when the body cannot use glucose, not enough	F 314		

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F 314	Continued From page 5 insulin made or the body cannot respond to the insulin), and nutritional deficiency. The 2/19/14 admission (MDS) Minimum Data Set 3.0 assessment indicated the resident had short and long term memory problems, severely impaired cognitive skills for daily decision making, and total dependence on the assistance of 1-2 staff with (ADLs)Activities of Daily Living including bed mobility. The MDS indicated the resident was at risk for developing pressure sores and frequently incontinent of urine. The MDS indicated the resident had a pressure reducing device to his/her chair, on turning/repositioning program, and had no current pressure sores. The 2/19/14 Pressure Sore (CAAs) Care Area Assessment indicated the resident required a 2 person transfer with a sling lift and had an abrasion to his/her right buttock which resolved 2/23/14. The CAAs indicated the resident was at risk for pressure ulcers secondary to urinary incontinence. The 2/13/14 Braden scale for predicting pressure sore risk score 15.(a score of 12 or less represents high risk) The 2/13/14 care plan instructed the staff to assist the resident with change of position before and after meals and at bedtime and to provide the resident with a pressure relieving cushion to all chairs. The 3/3/14 care plan revision instructed the staff to apply off loading boots to the resident's bilateral heels at all times except for transfers, (no preventative measures were in place for the resident's heels prior to 3/3/14 when he/she developed a pressure sore. Review of the 2/13/14 admission nursing	F 314		

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assessment revealed no pressure sores to the resident's heels.

The 3/3/14 at 10:15 AM, nurse's note indicated the staff called the nurse to the resident's room to assess an area on his/her right heel. The nurse's note indicated the resident had an unstageable (full thickness tissue loss) pressure sore covered by slough (dead tissue, usually cream or yellow in color) and/or eschar (dead tissue).The nurse's note indicated the pressure sore (localized injury to the skin and/or underlying tissue usually over a bony prominence, as a result of pressure, or pressure in combination with shear and/or friction). The note indicated the skin was purple/blue in color, and when staff applied pressure to the area it "squished" under the nurse's finger tip.

The 3/3/2014 weekly pressure sore progress report indicated the resident had an unstageable purple/blue "soft tissue" area that measured 3 by 3(cm)centimeters with no depth, no drainage, no odor.

The 3/3/14 blood laboratory results revealed the resident's total protein (a test measuring the total amount of protein in the blood) was low 5.9 (normal 6.0-8.3) and the resident's albumin blood laboratory (a test measuring the amount of this protein in the clear liquid portion of the blood) was low at 3.2 (normal 3.5-5.0) which could indicate malnutrition.

The 3/4/14 dietary summary indicated the resident was adjusting to new placement in a long term care facility and the resident received a low cholesterol diet and Glucerna (a calorie-dense medical nutrition supplement specially designed for people with elevated blood sugars), 1.2 calorie

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F 314	Continued From page 7 4 (oz) ounce twice a day. On 6/19/14 at 8:07 AM, Nurse Aide C stated he/she did not know how the resident acquired the pressure sore. On 6/19/14 at 9:30 AM, Nurse E stated the resident required the assistance of 1-2 staff with ADLs. Nurse E stated the resident constantly rubbed his/her heels and feet against the sheets when lying in his/her bed. On 6/19/14 at 2:30 PM, Administrative Nurse F stated the facility does not do weekly skin assessments or fill out a bath sheets unless the aide identifies a problem. On 6/23/14 at 2:00 PM, Administrative Nurse B stated the resident had no pressure sores on his/her feet when first admitted to the facility. Administrative Nurse B stated the staff placed Ted hose(Elastic stockings that compress the superficial veins in the lower limbs) on his/her legs every day in February and the resident had no intervention in place for the resident rubbing his/her feet against the sheets. Administrative Nurse B stated the staff placed the air mattress on his/her bed on 3/4/14 after the resident acquired a pressure ulcer to his/her right heel on 3/3/14. On 6/24/14 at 8:50 AM, Physician Assistant O stated if the facility knew the resident was rubbing his/her feet on the sheets he/she would expect the staff to apply Unna Boots (A compression dressing consisting of a paste, primarily made of zinc oxide, that is applied both under and over a gauze bandage, used on the lower leg for venous ulcers, phlebitis, sprains, and other disorders) or heel-lifts. A gentle cradling and cushioning of the	F 314		

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F 314	Continued From page 8 lower leg with the heel elevated in protective space reduces the chances for irritation or pressure points), change mattress or to place a pillow underneath the resident's ankles. Physician Assistant O also stated friction from rubbing his/her feet on the sheet may have caused the the pressure sore on the resident's heel. On 6/24/14 at 9:20 AM, Administrative Nurse B verified the resident had no intervention to prevent pressure sores to the resident's heel prior to the resident acquiring the pressure sore to his/her right heel. The facility's Revised March 2004 Skin Conditions policy indicate that residents admitted to our facility without pressure sores will not develop pressure sores. The policy instruct the staff to protect the resident against the adverse effects of pressure, friction, and shear. The policy instructed the staff to monitor the residents carefully for any open or pressure areas during their baths. The facility failed to provide interventions to prevent an unavoidable pressure sore to Resident #50's right heel.	F 314		
F 323 SS=E	483.25(h) FREE OF ACCIDENT HAZARDS/SUPERVISION/DEVICES The facility must ensure that the resident environment remains as free of accident hazards as is possible; and each resident receives adequate supervision and assistance devices to prevent accidents. This Requirement is not met as evidenced by:	F 323		

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F 323	Continued From page 9 The facility had a census of 51 residents. The sample included 13 residents. Based on observation, interview and record review, the facility failed to provide an environment free from accident hazards for 1 resident identified by the facility as cognitively impaired and independently mobile, and failed to transfer 1 resident with 2 staff as careplaned and failed to complete an assessment of the resident prior to transferring him/her to the bed. (#24) Findings included: - On 6/16/14 at 6:45 PM, during the initial tour observation revealed the following: A laundry room door unlocked with and on the cabinet: 2 containers of 160 count germicidal disposable wipes in an unlocked cabinet above the sink. The label on the containers read: " Keep out of reach of children, can cause irreversible eye damage, harmful if absorbed through skin, use suitable hand protection (gloves) when dispensing and using this product. " The door to the clean utility room on the 400 hall unlocked with the following items: 7 bottles of sparkle fresh mouthwash which read " Do not swallow, in case of accidental ingestion seek medical attention" 2 - 16 fluid ounce bottles of hydrogen peroxide usp 3%, with labels that read, " Keep out of reach of children. " 6 - containers of 160 count germicidal disposable wipes in the far left upper cabinet, with a label	F 323		

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that read: " Keep out of reach of children, can cause irreversible eye damage, harmful if absorbed through skin, use suitable hand protection (gloves) when dispensing and using this product. "

On 6/16/14 at 7:04 PM, Administrative Staff F verified the germicidal wipes should not be kept in the unlocked laundry room. He/she further verified the mouthwash, hydrogen peroxide and the wipes should be locked up at all times.

The facility ' s 1/13/14 Environmental Services/Laundry Policy stated products are to be kept in secured locations, not accessible to patients/residents or the public.

The facility failed to ensure the resident environment was free from accident hazards for the 1 cognitively impaired independently mobile resident who resides in the facility.

- On 6/16/14 at 6:35 PM, observation revealed the physical therapy room doors open, with no staff in sight. Further observation revealed a container of Super Sani Cloths on counter top and one in an unlocked cabinet with a label stating - keep out of reach of children, hazardous to humans and domestic animals, when using this product wear gloves, danger - causes irreversible eyes damage.

On 6/16/14 at 6:48 PM, nurse aide G stated staff usually keep the therapy room door open in the evening and the containers of Super Sani wipes are left out/accessible on the counter.

- Resident #24's annual (MDS) Minimum Data set 3.0 assessment, dated 4/13/2014, indicated

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the resident had severely impaired cognition and required extensive assistance of two staff for bed mobility, transfers, dressing, and locomotion on the unit. The MDS indicated the resident was unsteady and only able to stabilize with staff assistance when moving from a seated to a standing position and had two falls since admission to the facility.

The 4/17/2014 (CAAS) Care Area Assessment for (ADLs) Activities of daily living, stated the resident required assistance with transfers, ambulation and personal cares. The CAAs for falls indicated the resident had one fall from the couch and one fall out of his/her recliner. The CAAs indicted the resident required the assistance of 1 staff for transfers with a gait belt and a roller walker in his/her room. The assessment indicated the resident was at risk for falls, secondary to a history of falls related to his/her diagnosis of Parkinson'sdisease (a disorder of the brain that leads to shaking and difficulty with walking, movement, and coordination) and behaviors of getting up without assistance.

The Tinetti assessment tool, dated 4/10/2014, indicated the resident at risk for falls and required a the assistance of 1 staff for transfers and using a gait belt and a walker in the room and the assistance of 2 staff in the hall with one to follow the resident due to his/her gait.

The 4/22/2014 care plan instructed the staff to provide assistance to the resident with ADLs due to a self care deficit related to functional limitations. The care plan instructed the staff to assist the resident to ambulate with the assistance of 1 staff, a gait belt and a rolled walker, to place the bed buddy on the mattress at

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all times and to not leave the resident alone on the toilet. The care plan updated on 6/19/2014 directed the staff to assist the resident with two staff, a gait belt and a roller walker for all other transfers.

The 6/14/2014 at 11:50 AM, nurse's notes revealed the resident had slipped out of his/her bed while the nurse aide assisted the resident with morning cares. Nurse Aide K assisted the resident up and off the floor before notifying the charge nurse. The investigation report indicated the resident was lying on the floor next to his/her bed, another nurse aide got the resident up to the wheelchair after the nurse aide stated the resident had been sitting on the side of the bed and slid to the floor. Nurse Aide K stated he/she sat the resident up and put a gait belt on him/her to assist to the toilet before lunch and he/she slid off the bed. The nurse aide summoned the charge nurse after he/she had assisted the resident off the floor.

On 6/19/2014 at 7:35 AM, observation revealed Nurse Aide M and Nurse Aide N assisted the resident to sit on the edge of his/her bed with a gait belt. The resident stood, pivoted and transferred to his/her wheelchair.

The 2/09/2009 facility fall policy, indicated the facility would identify residents at risk for falls, on admission, at least quarterly and with any significant change in status be assessed of their risk for falls, manipulation of the environment to prevent falls, and appropriate management of those who experience falls. The post fall protocol directed the staff to assess the resident for any obvious injuries including a head to toe

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F 323	Continued From page 13 assessment of the resident, vital signs and neurological check with all suspected head injuries. The facility failed to provide adequate assistance for cognitively impaired Resident #24, who slid off the bed with transfer and then staff` assisted the resident up off the floor and to the bed without the nurse assessing the resident for injuries.	F 323		
F 329 SS=D	483.25(l) DRUG REGIMEN IS FREE FROM UNNECESSARY DRUGS Each resident's drug regimen must be free from unnecessary drugs. An unnecessary drug is any drug when used in excessive dose (including duplicate therapy); or for excessive duration; or without adequate monitoring; or without adequate indications for its use; or in the presence of adverse consequences which indicate the dose should be reduced or discontinued; or any combinations of the reasons above. Based on a comprehensive assessment of a resident, the facility must ensure that residents who have not used antipsychotic drugs are not given these drugs unless antipsychotic drug therapy is necessary to treat a specific condition as diagnosed and documented in the clinical record; and residents who use antipsychotic drugs receive gradual dose reductions, and behavioral interventions, unless clinically contraindicated, in an effort to discontinue these drugs. This Requirement is not met as evidenced by: The facility had a census of 51 residents. The	F 329		

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F 329	Continued From page 14 sample included 5 residents reviewed for unnecessary medications. Based on observation, record review and interview the facility failed to monitor for the effectiveness of an as needed pain medication and failed to provide ongoing assessment of medication refusal for 2 of 5 sampled residents. (#15 and #23) Findings included: - Resident #15's significant change (MDS) Minimum Data Set 3.0 assessment, dated 4/27/14 , indicated the resident had moderately impaired cognition and required limited assistance with bed mobility, transfers, dressing, toileting. The resident indicated he/she had frequent moderate pain from an infection in his/her foot. The resident received scheduled and as needed pain medication. The resident also received insulin, antidepressant and anticoagulation medications 7 days, and antibiotics 3 days a week. The 4/30/2014 (CAAs) Care Area Assessment indicated the resident received psychotropic medication for depression and on 4/24/2014 had an increase in mood symptoms of falling asleep or sleeping too much. The CAAs failed to address the pain medication the resident received. The 4/30/14 care plan for medications directed the staff to administer to the resident: Lortab, (pain medication) 7.5/325 (mg) milligrams, (PRN) as needed for pain, every 6 hours to the resident as outlined by the physician on 5/28/2014. The care directed the staff to monitor the resident for the effectiveness and for side effects of the medication. Review of the PRN medication documentation	F 329		

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revealed no results of the effectiveness documented after nursing had administered, Lortab 7.5/325 pain medications to the resident on - 5/27/14 x2, 6/2/14, 6/3/14, 6/11, 6/12, 6/18/2014.

Review of the nurse's notes on the days the staff administered the PRN medication revealed no documentation of follow up after the pain medication was administered to the resident.

On 6/19/14 at 9:58 AM, observation revealed Nurse A providing wound care to the resident. The resident tolerated the procedure well with no complaints of pain.

On 6/19/14 at 11:17 AM, Nurse B stated nurses are to document the effectiveness of a PRN medication. He/She verified the PRN medication sheet lacked documentation of results on the above days and the nurse's notes lacked documentation of follow up regarding the effectiveness of the PRN medication.

On 6/19/14 at 11:25 AM, Nurse A, stated nurses are to document the results or follow up after giving a PRN medication. He/she verified he/she had not followed up on 6/18/14 after administering pain medication to the resident.

On 6/19/14 at 2:00 PM, the facility's consultant pharmacist stated he/she had not yet reviewed the notes he/she had taken at the facility on 6/18/14 for the monthly report to the DON.

The 6/2014 facility medication administration policy, indicated the facility would administer medications upon the order of the physician. The PRN medications administered would be documented on the resident's PRN sheet, and if

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the medication was held or refused, a notation would be made on the resident's medication sheet. The policy stated each dose of the medication administered is to be properly recorder in the resident's MAR.

The facility failed to provide further assessment of the effectiveness of PRN pain medication for Resident #15, who received Lortab 7.5/325 mg, as needed for pain.

- Resident #23's physician order sheet indicated the resident had Vitamin D deficiency, Diabetes Mellitus (when the body cannot use glucose, not enough insulin made or the body cannot respond to the insulin), hypertension (elevated blood pressure), and depressive disorder.

The quarterly (MDS) Minimum Data Set 3.0 assessment, dated 4/6/14, indicated the resident had severely impaired decision making skills , extensive assist with (ADLs) Activities of Daily Living and received an antipsychotic (drug used to treat psychotic (loss of contact with reality that is marked by delusions, hallucinations, incoherence,and distorted perception)disorders, antianxiety (a medication used to treat mental or emotional reaction characterized by apprehension, uncertainty and irrational fear) , and antidepressant medication (a medication used to treat depression).

The 4/15/14 care plan instructed the staff to administer the resident's medications as ordered by the physician.

Review of the resident's June medical record revealed the resident had refused his/her medications on the following dates and times:

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F 329	Continued From page 17 6/16/14 at 7:30 AM the resident refused the following medications: Levaquin(an antibiotic medication), 500, (mg) milligram Vitamin D 3 (a medication for vitamin D deficiency) (1,000) units Norvasc (an blood pressure medication) 10 mg Amantadine HCL (drug used in the treatment of Parkinson's disease (slowly progressive neurological disorder characterized by resting tremor, rolling of the fingers, mask like faces, shuffling gait, muscle rigidity and weakness) 100 mg Klonopin (a medication used to control seizures) 0.5 mg Ritalin (mild central nervous system stimulant) 5 mg Zoloft (a medication used to treat depression and other mental /mood disorders)100 mg Janumet (a diabetic medication that helps control blood sugar levels) 50-500 mg Senna S (a medication used to treat constipation) 8.6-50 mg (2 tablets The resident refused the following medication on the same date at 6:00 PM: Janumet 50-500 mg Geodon (an medication used in the treatment of mental illnesses) 40 mg.	F 329		

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F 329	Continued From page 18 On 6/17/14 the resident refused the following medications at 6:00 PM: Janumet 50-500 mg Geodon 40 mg The resident refused the following medications at 8:00 PM on the same date: Folic acid (a type of B vitamin that's key for cell growth) 1 mg Senna S 8.6-50 mg (2 tabs) Vitamin D 3 (1000 units) On 6/18/14 the resident refused the following medications at 8:00 AM: Levaquin, 500, (mg) milligram Vitamin D 3 (1,000) units Norvasc 10 mg Amantadine HCL 100 mg Klonopin 0.5 mg Ritalin 5 mg Zoloft (a medication used to treat depression and other mental /mood disorders)100 mg Janumet 50-500 mg Senna S (2 tablets)	F 329		

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F 329	Continued From page 19 The resident refused the following medications at 8:00 PM: Folic acid (a type of B that's key for cell growth)1 mg Senna S 8.6-50 mg(2 tablets) Vitamin D 3(1000 units) 6/19/14 the resident refused the following medications at 8:00 AM: Levaquin, 500, (mg) milligram Vitamin D 3 (1,000) units Norvasc 10 mg Amantadine HCL 100 mg Klonopin 0.5 mg Ritalin 5 mg Zoloft 100 mg Janumet 50-500 mg Senna S 8.6-50 mg (2 tablets) The 6/17/14 at 10:30 PM nurse's note indicated the resident had refused all supper and evening scheduled medications. The 6/18/14 at 10:30 PM nurse's note indicated the resident barely agreed to take last dose of Levaquin for upper respiratory infection and the resident refused all breakfast scheduled medications.	F 329		

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F 329	Continued From page 20 Review of the nurse's notes from 6/16 to 6/19 revealed no documentation of notifying the physician or the director of nursing the resident was refusing his/her medications. On 6/19/14 at 7:16 AM, observation revealed the nurse offered the resident his/her medications and the resident refused by clenching his/her mouth shut and stating "no". On 6/19/14 at 1:11 PM, Nurse L stated when a resident refused his/her medications the staff notified the physician when he/she made rounds in the facility or if the resident looked like he/she had symptoms of withdrawal. On 6/18/14 at 1:48 PM, Administrative Nurse F stated he/she was not aware the resident was refusing his/her medications and he/she would expect the staff to notify the physician if a resident consecutively refused his/her medications. The facility failed to ensure adequate monitoring and to notify the physician regarding Resident # 23's refusing his/her medications on 4 consecutive days.	F 329		
F 431 SS=D	483.60(b), (d), (e) DRUG RECORDS, LABEL/STORE DRUGS & BIOLOGICALS The facility must employ or obtain the services of a licensed pharmacist who establishes a system of records of receipt and disposition of all controlled drugs in sufficient detail to enable an accurate reconciliation; and determines that drug records are in order and that an account of all controlled drugs is maintained and periodically reconciled. Drugs and biologicals used in the facility must be	F 431		

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F 431	Continued From page 21 labeled in accordance with currently accepted professional principles, and include the appropriate accessory and cautionary instructions, and the expiration date when applicable. In accordance with State and Federal laws, the facility must store all drugs and biologicals in locked compartments under proper temperature controls, and permit only authorized personnel to have access to the keys. The facility must provide separately locked, permanently affixed compartments for storage of controlled drugs listed in Schedule II of the Comprehensive Drug Abuse Prevention and Control Act of 1976 and other drugs subject to abuse, except when the facility uses single unit package drug distribution systems in which the quantity stored is minimal and a missing dose can be readily detected. This Requirement is not met as evidenced by: The facility had a census of 51 residents. Based on observation, record review and interview the facility failed to label medication appropriately for 2 of 9 who received insulin (#15 and #30) and failed to ensure the emergency kit antibiotics in 1 of 2 medication rooms had not expired. Findings included: - On 6/16/14 at 7:00 PM, observation during the initial tour revealed the following: 1) A vial of Humalog insulin for Resident #15, opened and undated. The physician's order for	F 431		

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Humalog 12 units before meals, 3 times daily, documented on the (MAR) Medication Administration Record, started 2/19/2014.

2) A vial of Humalog insulin for Resident # 30, opened and undated. The physician's order for Humalog (Humalog insulin 15 units, before meals three times a day, started 4/25/14) on the MAR as given 3 times daily.

On 6/16/14 at 7:05 PM, Nurse H verified the observation of the expired insulin medication and verified he/she was uncertain as to when the 2 insulin vials were opened or if they were expired. Nurse H verified the vials were currently used for the 2 residents who received insulin 3 times daily.

On 6/16/14 at 7:05 PM, observation revealed the emergency kit on the 100 hall medication cart had an expiration date of 3/2014 on the outside of the kit and 1 vial of Ceftriaxone (antibiotic), 1 gram, powder for injection, had an expiration date of 3/2014. Nurse A verified the findings at the time of the observation.

On 6/17/14 at 5:41 PM, Nurse F stated staff are to date insulin vials when opened and are to also put on the expiration date. He/She stated the facility had changed pharmacist consultants 6 months ago and then 1 month ago and stated the pharmacist consultant had not reviewed the medications for expiration. He/She verified nurses are responsible to check expiration dates on the medications and the emergency kit.

The facility undated multiple -dose medication vials policy,indicated the staff would date when

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F 431	Continued From page 23 the vial was opened. The vial would be disposed of 28 days from the date opened, or sooner if the manufacturers expiration date falls before the 28 days. The facility undated medication disposal of discontinued or expired policy indicated the multi-dose vials must be disposed of when the vial has been opened and there is no date when it was opened, and outdated, expired or discontinued medications would be disposed. The facility failed to label insulin vials to ensure the medication was still effective for 2 unsampled residents and failed to ensure medications for emergency use were not expired.	F 431		
F 441 SS=D	483.65 INFECTION CONTROL, PREVENT SPREAD, LINENS The facility must establish and maintain an Infection Control Program designed to provide a safe, sanitary and comfortable environment and to help prevent the development and transmission of disease and infection. (a) Infection Control Program The facility must establish an Infection Control Program under which it - (1) Investigates, controls, and prevents infections in the facility; (2) Decides what procedures, such as isolation, should be applied to an individual resident; and (3) Maintains a record of incidents and corrective actions related to infections. (b) Preventing Spread of Infection (1) When the Infection Control Program determines that a resident needs isolation to prevent the spread of infection, the facility must isolate the resident.	F 441		

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F 441	Continued From page 24 (2) The facility must prohibit employees with a communicable disease or infected skin lesions from direct contact with residents or their food, if direct contact will transmit the disease. (3) The facility must require staff to wash their hands after each direct resident contact for which hand washing is indicated by accepted professional practice. (c) Linens Personnel must handle, store, process and transport linens so as to prevent the spread of infection. This Requirement is not met as evidenced by: The facility had a census 51 residents. The sampled included 13 residents. Based on observation, record review and interview the facility failed to provide a sanitary environment to prevent the development and transmission of disease and infections for 4 of 9 residents residents who received oxygen and/or respiratory therapy. (#1, #25, #45 and #14) Findings included: - On 9/15/2014 2014 at 8:10 AM, observation revealed resident #1's oxygen tubing and nasal cannula (nose piece) attached to the oxygen concentrator laying on the floor in the resident's room. On 6/17/2014 at 9:10 AM observation revealed the following: 1) Resident #25 had an oxygen canister attached to the back of his/her wheelchair and stored in a cloth bag with the tubing thrown up and over the	F 441		

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F 441	Continued From page 25 wheelchair and the nasal cannula hanging down almost touching the floor. 2) Resident # 45 had his/her oxygen tubing and cannula thrown up on top of the oxygen concentrator. 3) Resident #14 had his/her oxygen tubing thrown on top of the oxygen canister and the nasal cannula placed on the arm rest of the residents recliner. On 6/19/2014 at 9:20 AM, Administrative Nurse F, verified the nasal cannula would become contaminated if laying on the floor, bed or concentrator and staff are to properly store the residents' nasal cannula while not in use. The facility 2/1988 oxygen storage policy indicated the staff would discard disposable masks, cannulas and tubing after use or when they become soiled. The facility failed to provide a sanitary environment to prevent the development and transmission of disease and infection for 4 residents in the facility, who received oxygen and/or respiratory therapy.	F 441		